CROWSON

vs

WASHINGTON COUNTY

RYAN T. BORROWMAN

April 17, 2018

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF UTAH, CENTRAL DIVISION

* * *

MARTIN CROWSON,
Plaintiff,
vs.
WASHINGTON COUNTY, et al.,
Defendants.

Case No. 2:15-cv-00880

Deposition of:

RYAN T. BORROWMAN

COPY

April 17, 2018

1:00 p.m.

WASHINGTON COUNTY TREASURER OFFICE
197 East Tabernacle Street
St. George, Utah

* * *

Linda Van Tassell
- Registered Diplomate Reporter -
Certified Realtime Reporter

A P P E A R A N C E S

For the Plaintiff: Ryan J. Schriever
SCHRIEVER LAW FIRM
51 East 800 North
Spanish Fork, Utah 84660

For the Defendant Washington County: Frank D. Mylar
MYLAR LAW, PC
2494 Bengal Boulevard
Salt Lake City, Utah 84121

For the Defendant Larrowe: Gary T. Wight
KIPP & CHRISTIAN
10 Exchange Place, 4th Floor
Salt Lake City, Utah 84111

Also Present: Brian Graf

* * *

I N D E X

P R O C E E D I N G S

RYAN T. BORROWMAN,

called as a witness on behalf of the plaintiff, being duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. SCHRIEVER:

Q. Please state your full name.

A. Ryan T. Borrowman.

Q. How do you spell Borrowman?

A. B-o-r-r-o-w-m-a-n.

Q. What is your date of birth?

A. November 8, 1975.

Q. Where do you currently live?

MR. MYLAR: I want to object to his personal address.

Q. Sure.

A. Washington Fields.

Q. How long have you lived in Washington Fields?

A. Maybe four years.

Q. Do you have any plans of moving anytime soon? Is that no?

A. Yeah. No. Sorry, I forgot.

Q. I know you've had a chance to talk with

your attorney about what a deposition is. I like to always explain a little bit at the beginning. Your deposition is my chance to ask you questions. You're under oath so you're obligated to tell the truth. What I'm after is your recollection and memories of events. I may also ask you for your interpretation of some facts --

A. Okay.

Q. -- your mental impressions. If I ask you for the mental impressions of other people, your attorney will probably object.

A. Okay.

Q. In most situations like that he can object and I can still ask you to answer the question --

A. Okay.

Q. -- because we can try to figure out how it is you come to think things or know things.

A. Okay.

Q. He's preserving the objection for later on if we have to go to court and I try to use it for reasons he doesn't think is proper.

A. Right.

Q. Along those lines, everything that you or I or anybody here says is being recorded and will

be written down in booklet. So if I do remind you to say yes or no if you've shaken your head, I'm not trying to be rude.

A. Yeah.

Q. If you need to take a break for any reason at all just let me know. That's not a big deal.

A. All right.

Q. If I ask you a question that you don't feel like you can completely or honestly answer or if you don't understand a question that I'm asking, tell me that and I will do my best to try to rephrase it.

A. Okay.

Q. Any questions about the deposition process?

A. Not that I understand.

Q. Okay. What is your current job with Washington County?

A. I'm not currently employed with them.

Q. Where do you work?

A. Riverview Medical as a doctor of nursing practice.

Q. When did you stop working for Washington Jail?

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A. Close to three years, maybe two and a half, I think. I don't recall exactly. It's been a while.
Q. What was the reason you stopped working for Washington County?
A. I gave a resignation because I was going to work in addiction medicine where I became a nurse practitioner.
Q. Where did you go to work first after Washington County?
A. Brookstone Medical Center.
Q. How long did you work there?
A. About six to -- I don't recall dates very well so this is -- probably six to eight months.
Q. What kind of work were you doing at Brookstone?
A. Addiction medicine for heroin addiction and opioid addiction.
Q. As a nurse practitioner are able to prescribe medication?
A. I am. But when I was working the county I was not.
Q. Okay. After Brookstone, where did you work?

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A. Desert Pain Management, Desert Pain and Spine.
Q. Were you doing pain management medicine there?
A. Yes.
Q. Any addiction medicine?
A. No. That's where I got my Suboxone and I was working on my doctorate which had to do with safe opioid management just because of the crisis that's going on so my doctorate was focused on that and I was trying to implement that at Desert Pain.
Q. So we can call you Dr. Borrowman?
A. No, you can't because when I worked at the jail, no.
Q. Where did you get your doctorate?
A. What's that?
Q. Where did you get your doctorate?
A. Frontier Nursing University. It's in Kentucky.
Q. And after the pain management clinic where did you go next?
A. Riverview, where I'm currently at.
Q. How long were you with the county?
A. Almost ten years.
Q. Where did you work before the county?

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A. It was a care center, Red Cliffs Care Center.
Q. Was it an assisted nursing facility?
A. Uh-huh.
Q. Is that yes?
A. Yes. Sorry.
Q. Obviously you've changed now to where you're a nurse practitioner but were you were an RN before?
A. Yes.
Q. Ever an LPN?
A. I was for a year.
Q. What year did you get your LPN?
A. It was around 2005 or 2000 -- I think 2005.
Q. When did you get your RN?
A. A year later from whenever -- I had one year left.
Q. Okay. And that would have been about the time you were working for the county in the jail?
A. Right. It wasn't very long after that I started working there.
Q. In the ten years that you were with the county did you always work in the jail?

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A. Yes.
Q. Where did you get your RN?
A. My RN from Dixie State University, but it wasn't Dixie State University at that time.
Q. It's changed.
A. It's growing.
Q. And then your LPN?
A. Same.
Q. Have you ever had -- well, let's not go to ever. I'm going to try to break things up so that we're talking about the knowledge and experience and qualifications you had at the time when this incident with Mr. Crowson happened, which was June of 2014. I understand that since that time your education and experience has expanded quite a bit. So when I'm asking these questions I want you to try to remember what it was at that time.
A. I'll try to do that.
Q. In connection with your work at the prison, had you received training in relation to recognition of brain injuries?
A. No specific training that I can remember.
Q. How about as part of your LPN or RN training?

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A. Yes, there's courses there that we take. I don't remember specifically but we do touch on psychological and behavioral problems during those years.

Q. How about recognition of alcohol withdrawal symptoms?

A. Yes. Both in my LPN and my RN year. And then we would also review those I think in our yearly trainings, I believe. I'm not 100 percent sure but I know it was very highly -- it's a highly discussed topic since we see so many people. I don't know if it was inhouse or in our yearly training.

Q. What yearly training did you do?

A. The county has yearly training. Just staff training that they do.

Q. And you address alcohol withdrawal symptoms specifically?

A. Not that I really -- I don't know that I can recall exactly if it was specific or not.

Q. Do you recall if it was specific to withdrawal from other types of drugs?

A. There was a section every year but maybe I'm -- it seems like that's where it was at. I can't recall exactly.

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Q. How would you describe the training? What did they teach you?

A. Number one, to notice when somebody is behaving differently and pupil dilation, those types of things where they could be showing signs of being on a stimulant, or pupil constriction that could be showing signs of brain or alcohol, those types of things. They tried to keep it pretty simple, especially so deputies even would be able to recognize it.

Q. Did they have any type of assessment that you could do to determine the severity of withdrawals so they could determine what treatment is appropriate?

A. At the time -- I don't know if it's there any longer but one of the nurses posted on a little whiteboard that we had a thing that showed specifically heroin and alcohol withdrawal but didn't show anything for meth or -- but I don't even know if that's there anymore.

Q. Do you know what the criteria were?

A. Heroin you go through the -- there was a point scale for like if you saw goose bumps or if their pupils were dilated or if they were sweating, tremors in their hands, those types of things, and

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you would add up the point system and that would tell you how bad they were in heroin withdrawal.

Alcohol withdrawal, I don't recall there being a point system but it was you were looking for delirium and then you were looking for tremors and looking for unstable vital signs. That's all I remember. There could have been more but that's all I remember of it.

Q. Would that include an increase in anxiety?

A. For which one?

Q. For alcohol?

A. I don't recall if that was on that list. I know that I knew that, to be looking for anxiety issues.

Q. You say you knew that?

A. Uh-huh. Where I picked it up, I don't recall. I don't know if it was on that paper.

Q. How about hallucinations?

A. That would be delirium.

Q. Is change in mental status something different than delirium?

A. No. That's what you would be looked for with alcohol withdrawal.

Q. How about a temperature above 100.4, is

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that something you would look for?

A. If it is, I don't remember that. I'm sure it probably is but --

Q. Increases or decreases in blood pressure and heart rate?

A. Right. Stable vital signs is --

Q. What about insomnia?

A. That would be on the list but you would have to take into account everything else for insomnia to really be a specific concern. Pretty much everyone in the jail could have insomnia just because of the location. If someone just came to me and said, "I've got insomnia," I wouldn't be thinking alcohol withdrawal.

Q. Okay. How about abdominal pain?

A. If that's on the list, I don't recall it.

Q. Changes in responsiveness of pupils?

A. Yeah. That would be the -- I think I mentioned that already.

Q. What about heightened deep tendon reflexes?

A. Yes.

Q. Ankle clonus?

A. Yes. And that can also be back

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injuries, so that alone you wouldn't be thinking alcohol withdrawal.

Q. But if you saw somebody that had most or all of these --

A. Oh, yeah. It would be -- I would be thinking alcohol withdrawal.

Q. Okay. And did the jail have criteria like this that you were required to use when determining alcohol withdrawal?

A. Mostly I went off memory. I don't remember if there was anything specific. We were all trained in that.

Q. Did the jail have criteria that you would look at if you were considering a brain injury?

A. There was the Glasgow Coma Score -- Glas-cow, however you want to say it.

Q. After Dr. Glasgow, who was a woman by the way.

A. I did not know that.

Q. It's on Facebook.

A. It could be or couldn't be true.

Q. It's on the Internet. Any other criteria you'd look at other than the Glasgow Coma Score?

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A. No. That was pretty much the deciding one.

Q. Are you familiar with the CIWA-AR scale of alcohol withdrawal?

A. Yeah. I wouldn't be able to -- I've encountered it. That was one of the scales that was used when I was working at Brookstone but I didn't commit it to memory. I wouldn't be able to recite it back to you.

Q. Okay. All right. While you were working at the jail did you ever record notes or charts outside of CorEMR?

A. No, I didn't.

Q. And when you would make an entry into CorEMR, was that your own account? You had a password --

A. Yes.

Q. -- that would log you in?

A. Right.

Q. And if you entered a note, would it automatically assign you as the person doing that?

A. Yes.

Q. Did it also automatically assign a date and timestamp?

A. That was my understanding, although I

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didn't look into how it actually did things and kept track in a database. I just assumed that it did.

Q. Did you have access to go back in and change or modify any prior entries that you had made?

A. I think somebody could but if they made the change, I think it would track it. So I don't think you could make changes with it. That's my understanding. If it's possible, I'm not aware of how.

Q. Okay.

A. But I think an administrator could unlock something but I would assume that that would be tracked, too.

Q. Was it your practice to always document interactions when you were seeing patients?

A. That was always my -- there were times that I would not be able to because of the workload, trying to go through and assess everyone, but because of the time constraints or how many people, there were times that I would not be able to.

However, that being said, if there was ever a situation where there was something abnormal, I wouldn't -- I would always make sure that that was in.

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Q. How about something routine like checking somebody's vital signs, is that something you would chart in CorEMR?

A. If I were in charge of booking, probably -- same rules there. If it were a busy day I wouldn't always get it done. On the days that were slower and that we had time to get everything caught up, but I would take vitals with everyone even if I didn't chart it.

Q. Did you take vitals with everyone you saw?

A. I want to say yes. I'm sure there's some times when I may have missed somebody but to my recollection I always hooked the tree around, the vitals tree, especially if it were a detox or one of the med cells. I can't say that for some of the intake cells where the people were sitting there waiting for -- to be moved somewhere but in med cells, yes.

Q. How many inmates did you see on a daily basis?

A. In booking it would just depend on how many inmates were brought in and how many were in med observation. And then if I didn't have booking and I had kites and tasks, which are the medical

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requests that the inmates put in, that could range anywhere from five to 25, just depending on the day.

Q. How is it that you would know what inmates to see?

A. I don't remember if CorEMR or if -- there's a new computer system that they put in that they would be able to put it in on the kiosk. I don't recall if that was active at the time. And, if it wasn't, then they would put in a medical request kite. There's a box in every single block that they can just go up, grab one, fill it out and then they put it into a little box that the deputies get. So we'd get -- we call them kites because the inmates would say they were flying us a kite or flying a kite to whatever and they would -- we would get those every day. We would see everyone for the kites every day that came to us.

Q. You mentioned some different areas. One was booking, one was med observation cells --

A. Whoever had booking had med observation cells.

Q. Okay. And then you also had just the general population, right?

A. Yeah. We called it doing kites and tasks.

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Q. Did people in the med observation cells have to put in requests?

A. No. We would see them multiple times a day, so whoever was in charge of that would go up there. Initially they would do vitals on everyone and then from there they would walk through multiple times a day in booking to look over them.

Q. Does that mean that you went in and took vitals on the inmates multiple times per day?

A. Each nurse normally would do it one time.

Q. Any other times to check them to see if they're responsive?

A. Skin color, if they were sleeping, if there were respirations, if they were talking to themselves or just anything abnormal.

Q. If it was abnormal, then you would note it.

A. Yeah.

Q. If it was normal then --

A. Then I wouldn't.

Q. In the medical observation cells was it your practice to be more vigilant about charting things?

A. It was my practice, yes. I tried. If I

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missed something it was either -- I can't think of a situation but just if something crazy was going on, maybe a suicide attempt or something in the back where we were completely distracted for a little bit. It would had to have been something really big for me to miss it, though.

Q. Is the medical observation cell the same as the detox cell?

A. Yeah. There's also some that are padded where if we feel somebody is a danger to themselves they would be there. And then for long-term stable patients that we wanted to observe but we were a lot more comfortable that they were stable, there were some cells that you could still see in there but they were different than the detox cells and they were technically medical cells but the terms are interchangeable. If they were brought up for medical observation, we wanted direct eyes on them, we would call one of the detox cells a medical cell where the deputies in booking had constant visual on them.

Q. Was there a deputy that would accompany you when you would do visits in the med cells?

A. Yes. Every single time. I couldn't go in there without a deputy.

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Q. What about when inmates came back to the exam room?

A. There's a deputy there as well.

Q. Is that the same deputy throughout the day?

A. No. It could be a different deputy. Normally a deputy from booking would escort us in booking and a deputy from the blocks would escort us in the blocks. But it could, just depending on the need. I guess one of them may come up from the blocks to go around with us in booking but we couldn't be alone.

Q. Okay. Were you able to enter the charting with CorEMR from the medical observation cells?

A. No.

Q. You would have to go back to the exam room --

A. Right.

Q. -- with your own computer?

A. Uh-huh.

Q. Is that yes?

A. Yes.

Q. My understanding is that Dr. Jim Larrowe was the medical director for the county.

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A. Uh-huh.
Q. Is that a yes?
A. Yes.
Q. What's your understanding of what his role was?
A. He was the doctor. You couldn't do anything without the doctor okaying it. As a nurse you don't have that authority. So if you see something, you call the doctor and ask what he wants to have done.
Q. It is the doctor who is ultimately responsible for the inmates' care, correct?
A. That's how the entire medical system is. Not just there but nurses at the hospital, everyone reports to a doctor.
Q. Right.
A. That's just part of the hierarchy.
Q. And the nurses, before they administer medication, get an order from the doctor.
A. Uh-huh.
Q. Is that a yes?
A. Yes.
Q. And nurses before they draw blood have to get an order from the doctor?
A. Yes.

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Q. Nurses before they send anything out for some kind of test like an x-ray --
A. Yes, they do.
Q. Was there an x-ray at the jail?
A. No. We had to send them to the hospital.
Q. Was there any type of imaging capability at the jail?
A. No. Not that I'm aware of.
Q. If you take a blood draw how would you find the result of that?
A. We would send it to our lab and they would send us the results.
Q. What are nurses authorized to do without a doctor's order?
A. The whole nurse structure is you can do a nursing assessment. We call it ADPI assessment. It's been a while since I did that. You're basically going through the same steps as a doctor in assessing, evaluating, implementing and going back and making sure that what is implemented occurred.
You can do things like Gatorade if you feel like the patient is dehydrated, if you feel like the patient is -- there's nothing real medical,

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really, I guess. You're just going through and doing an assessment to look for simple things that they can discuss with them, how they could better handle a situation. Just do some general things like that. I don't know if that's very clear but --
Q. Clear as mud. So this ADPI, that's an acronym?
A. Yes.
Q. A stands for assessment?
A. Uh-huh.
Q. The D stands for diagnosis?
A. Right. So you've got a nursing diagnosis which is different than a doctor's diagnosis.
Q. In what way is it difference?
A. For instance, dehydration, for example. You don't necessarily have any supporting documentation like a lab result. You can't order lab results to be able to say a person is dehydrated but if they tell you, "I'm thirsty. I haven't been drinking a lot of water."
So my diagnosis of dehydration may include talking to the doctor about it and getting a medical order for IV or something, something that I couldn't do as a nurse. But I could say, "Let's

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start pushing water. Let's have you drink. Let's get you some Gatorade." Does that clear it up any?
Q. So using this hypothetical then, you could call the doctor and say, "Hey, I believe this patient is dehydrated. Can we go ahead and start an IV on them?"
A. Right. If I felt like just standard things that a normal person could do, like drink water, were not going to be enough.
Q. Would it be standard practice for you to make that type of a recommendation to a doctor?
A. Yes.
Q. And the doctor could say yes or no?
A. Yes.
Q. As far as planning goes, what does the P stand for?
A. That's where you start to -- you're going to come up with what you're going to do. So if the plan is talk to the doctor, get orders, then that's what you're going to do. If the plan is to hydrate with Gatorade, that's what the plan is. So it's just what you're going to do to try and address the diagnosis that you came up with.
Q. Okay. And what is the nurse's role in planning as opposed to the doctor's role in

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planning?
A. The nurse can't make any medical diagnoses, so to speak. So if they feel like a situation is needing more than just something simple, you have to talk to the doctor in order to see if he feels, number one, that something more needs to be done, or, if he agrees that you just need to do what you were going to do, push water or whatever. They're different. A nurse can't order things, so to speak, that isn't commonly available to the normal person at home, if that makes sense.
Q. Sure. As a nurse was there such thing that you feel like a lot of times you knew what the inmate needed as far as treatment goes but you still needed to get a doctor's approval for that?
A. On almost anything that was related to drugs, alcohol, blood pressures, there were very few options available to a nurse. You could just give the inmate what's available to the general population. So a majority of what I did, anyway, involved the doctor.
Q. Okay. And those conversations with a doctor, specifically Dr. Larrowe, would that consist of you calling him? I'm going to break this down. Would you call him?

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A. Yes.
Q. And my understanding is he was there at the jail one time a week?
A. Most of the time two times a week.
Q. Two times?
A. Tuesday and Thursdays.
Q. How many hours would he be there?
A. Just depends on how many patients he had to see. I've seen him there for as short as maybe 30 or 40 minutes and a couple of hours, maybe. Just depends on what he had, if there was something complex or not. I don't remember that very well. It's been a long time.
Q. Did he ever send out a PA or nurse practitioner --
A. Yes.
Q. -- instead of him coming out?
A. Yes.
Q. How often did that happen?
A. You know, that was so long ago. He hasn't had a PA or a nurse practitioner since before -- Amy, who was the nurse practitioner there, didn't want to come out so I couldn't tell you how long it's been but I think maybe the last one was Justin Brinkerhoff. That would be -- I don't

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remember, but very rarely before that. I mean Justin would come out at that time but that was, I believe, long before this ever happened.
Q. So your memory was in 2014 it was mostly Dr. Larrowe who would come?
A. I believe so. I could be wrong but --
Q. Do you have any criticisms of the way that Dr. Larrowe handled inmates?
MR. MYLAR: Objection. Lack of foundation.
MR. WIGHT: Join.
Q. You can still answer.
A. No. I felt like he -- I think he was very fair with then. I know that there was even a time or two that my perspective was that the inmate was lying or that all the data that inmate was giving me was not correct but when he went before Dr. Larrowe he seemed to really get down and go through all of the data and listen to them. He would make decisions that from my initial assessment I wouldn't have come to without digging as deep as he dug, so I think he really tried to do what's right for the inmates.
Q. All right. Circling back to where we were. We were on a little side tangent for a

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minute. You were talking about planning. So you had mentioned that you could call Dr. Larrowe. If he wasn't there on the site you could call him and you could have a conversation, correct?
A. Yes.
Q. As part of that conversation was it your practice to give him the medical history of the inmate that you were observing?
A. Yes.
Q. How about describing the symptoms that they were having?
A. Yes.
Q. Did you give him your thoughts on what was happening with the inmate?
A. That would be standard for me, yes.
Q. Did you also tell him, make recommendations as to what you thought would be appropriate treatment?
A. I didn't. I know of nurses that will do that but unless -- I would question him if I thought maybe he was making a decision that because I hadn't explained things but I wouldn't just tell him I think you need to do this.
Q. But if you had sensed that he had maybe not understood the situation as you did, then you

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would kind of follow up and provide more information, provide additional information.
A. Right. Or he would oftentimes, if he didn't feel he understood it, he would say, "Okay, I want you to go up and check this out and this out and get more information for me."
Q. Okay. And then implementation, you mentioned that is --
A. That's when you take what the doctor ordered and you actually do it. So if he says give them blood pressure medication, you're going to administer blood pressure medication. So that's the implementation part.
Q. Are there some limitations in the jail about implementing plans?
A. I'm not sure I understand.
Q. Let me give you a hypothetical. Let's say Dr. Larrowe said to you, "Take a blood draw from an inmate," but maybe his veins were scarred from heroin use or some other thing and you were unable to get the blood in that way, are there other avenues you may have to try to follow up on implementing that plan or do you abandon the plan or what do you do?
MR. MYLAR: Objection. Lack of

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foundation. Incomplete hypothetical and calls for speculation.
A. So in that situation I would always send them to the hospital because they've got Doppler ultrasound that they can find veins. So even there I wouldn't say that we were limited because we have an ER that was always available to us.
Q. And then the evaluation part of the ADPI method, what does that entail?
A. You implement it. Sticking with the blood pressure example, you're going to start checking blood pressure and see if the blood pressure starts to improve over the next day or two. You're going to be tracking to see if what was implemented is working. And, if it's not, you're going to start over and start going through it. If it's working, you're going to keep tracking it and really kind of just goes from there. It doesn't circle back around.
Q. You take a step back and you look and see is what we're doing working?
A. Right.
Q. If not, what can we do different?
A. Right.
Q. How often should you in a shift or in a

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week or in a day take that evaluation status where you're looking at what you're doing?
A. It depends on what you're implementing. If it's like a blood pressure medication, some of those can be as effective as they're going to be in a half hour. Some of them are going to take three or four days to build up enough in the blood to change it, so it just depends on what it is you're implementing how quickly you feel you need to circle around.
Q. And the doctor isn't out there every day so the nurse has to make that judgment call.
A. It's the same in any medical situation, care center or whatever it is, the doctor is not there every day.
Q. As a nurse do you consider yourself the eyes and ears of the doctor?
A. Yes.
Q. And along with that requires critical thinking, correct?
A. Yes.
Q. Analysis?
A. Uh-huh.
Q. Is that a yes?
A. Yes. Sorry.

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Q. Have you reviewed any documents in preparation for your deposition?
A. I looked over my assessment, my initial assessment and then the note that I did to send him to the hospital.
Q. You did his initial assessment and booking?
A. Yes.
Q. Did anything stand out to you in that as being --
A. Abnormal?
Q. Yeah.
A. No. The patient -- I actually remember him coming in. I had seen him before. I had multiple interactions with him. Not always on a medical. Just we like to talk to people. He denied having done anything. The officer I remember saying, "He says he hasn't done anything but we have been told that he did heroin a couple of days ago."
Q. So on the intake form it says that he had done heroin a couple of days ago. Let me pull it up. Page 488, are these your intake answers out of CorEMR?
A. Oh, yeah.
Q. Okay.

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A. It is. He said -- and I remember this. I did not put the officer but it should have said officer because he denied the substance abuse. That's why I marked no. But then he also denied the signs and symptoms of withdrawal when I asked him, too, but he denied any substance use. The officer is where I got this from. The officer states that he took heroin two days ago but the patient still denied any signs or symptoms. Like, "No, I'm not withdrawing."

Q. Did you observe any signs or symptoms of withdrawal?

A. I did not.

Q. Is it your understanding that signs and symptoms of withdrawal from alcohol typically begin 48 to 72 hours?

A. Yes. That was heroin, though.

Q. Is it different with heroin?

A. Yes.

Q. How long is that?

A. You start to get symptoms -- depends on how heavy their use is but you can get symptoms as soon as four or five hours afterwards. Normally 24 to 48 hours later you're in full-blown withdrawal. But it is different than alcohol. I wasn't cued

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into any alcohol on that.

Q. It may take a little while longer to get started.

A. Yeah.

Q. The heroin starts really quickly. Does the heroin withdrawal end quicker than alcohol withdrawal?

A. Not necessarily. Depends on the person. Each person metabolizes the opioid. Now we're getting into knowledge after.

Q. Okay. And that's fine. I am curious about that so I want to --

A. Some people can take seven, eight, nine days to clear the opioid out of their system. Alcohol withdrawal, that one is a lot more dangerous. Where no one really dies from opioid withdrawal, you can die from alcohol withdrawal. So normally, in my setting, if I suspected that someone was going through opioid withdrawal, I would expect eight to nine days.

For alcohol, depends on how quickly you get the medication in. If you get medication quickly, you can take them out of withdrawal pretty quick. There again, depends on how the body responds to the medication and you have to give it

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time to work to reverse things. But alcohol withdrawals typically -- I would say that I don't have as firm of dates on alcohol.

Q. And by medication, do you mean benzodiazepine?

A. Yeah.

Q. And if you get it into them, how long would you expect their symptoms to continue?

A. Well, there again --

Q. What's the range?

A. If the person wasn't doing better after a couple days I would get them out of my care and send them to the hospital.

Q. If a person started withdrawal symptoms 14 days after their last drink, would you think it was withdrawal symptoms?

A. No, I wouldn't. Do you mind if I tell you what I would be thinking, though?

Q. Sure.

MR. MYLAR: Just wait until he asks the question.

A. A jail setting is kind of a special situation where they can get illegal things down in the blocks.

Q. Sure.

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A. So if someone came in and they hadn't gone through withdrawals and they presented 14 days later with those symptoms I would think they had been getting and maintaining the alcohol level somehow in the block. I would think that's a possibility.

Q. Okay. Would you investigate as to whether that was in fact the case?

A. What do you mean?

Q. I mean would you try to confirm that -- let me give you some background. We had Deputy Lyman in here and he told us about homemade alcohol and black tar heroin and other things. Would you try to confirm whether or not they had received those types of things?

A. How -- I'm not sure what you're asking.

Q. Would you ask them?

A. I would ask them. I wouldn't expect them to admit to it.

Q. What if they had been in a block lockdown?

A. In that situation the deputies would go in, turn up the whole room to try and find something. It's a little different than being in a room of 60 people.

Q. Right. Were you aware that Mr. Crowson had been in a block lockdown --

MR. MYLAR: Objection. Assumes facts not in evidence. Go ahead.

A. I didn't know that.

Q. Would that be something that you would want to consider in determining whether you thought it was from withdrawal?

A. There again, it's kind of difficult -- I wouldn't know how long they'd in there and I don't. You would really have to get down and start pulling up history. When you're trying to deal with a patient who is struggling, you don't really have all that time to just go back and research all the different facts. And so your first priority is the patient, to try and stabilize them. So even though you're trying to get a good history, sometimes the priority doesn't go there first.

Q. In the jail setting did you ask the deputies what they knew about that?

A. Oh, yeah, there's open communication.

Q. Did you have access to the Spillman records?

A. I did. That was not something that I got into very often.

Q. Why not?

A. I just deal with the patients. And the other thing is -- my personal is that I didn't want to mix the two, medical versus corrections. When a patient came down to me, he was full medical. I didn't care what he had done, where he was. My focus was there.

Q. Did you notice anything abnormal about Mr. Crowson during the process on June 11, 2014?

A. No.

Q. He seemed alert and oriented?

A. Uh-huh.

Q. Is that a yes?

A. Yes.

Q. Did it seem like he was under the influence of any substances?

A. At the time, no.

Q. Was he compliant with instructions?

A. I don't really give instructions. I just ask questions. He seemed fine to me.

Q. Did you notice anything about his inability to respond appropriately?

A. He seemed normal.

Q. Okay. I'm looking at page 501, just for the record here. These are the CorEMR notes. It

looks like you didn't see him medically until 7-1-14, July 1, 2014.

A. Okay.

Q. Is that accurate?

A. The intake, is that what you're talking about?

Q. After intake. Then you don't see him again until the 21st.

A. That's accurate.

Q. Okay. Do you have any independent memory of seeing him anytime other than booking around July 1st?

A. I don't.

Q. Okay. What time did you come on shift on July 1st?

A. My shift started at seven. I don't know what time I got there.

Q. This chart note says it was at 2:15 p.m. Do you know if that was the time you saw him or if that was the time that you charted?

A. That was the time I charted.

Q. So you probably saw him earlier in the day?

A. If I remember right, it was in the morning on my initial rounds. I'd have to see what

time the hospital actually saw him.

Q. Okay. You wrote down he was able to verbalize multi-word answers.

A. Uh-huh.

Q. But physical movement is delayed.

A. Right.

Q. Describe what you think was a movement that was delayed.

A. Describe, I'm not sure what -- let's say I were to hand him a cup to take a drink. The hand wouldn't just reach out and grab it. It would be delayed. It was kind of slow motion to grab the cub. I mean he was still answering, doing appropriate things. Everything just seemed delayed, as I recall. That part I don't remember as well as I probably want to.

Q. There's nothing in here about his vitals.

A. Yeah. So on that -- I do vitals on rounds. With him I went in, saw the obvious symptoms and immediately called the doctor because they were severe enough, in my mind, that I just wanted to get him out and over to the hospital.

Q. Why did you think they were severe?

A. Because he'd been there two days and on

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the third day is when I would have really had my red flags up anyway. So I just thought through it and I figured in that time let's talk to the doctor to send him.

Q. So, in your mind, changed mental status that's been going on for two days, that's a basis to send him to the hospital.

A. Yes.

Q. Did you call Dr. Larrowe?

A. Yes, I did.

Q. And did you recommend to Dr. Larrowe that he send the patient to the hospital?

A. I don't recall the exact conversation. I would assume that's how it went. Normally, I just call and say, "Hey, this patient is demonstrating this. He's been there for a day or two. I'm concerned. I'd like to get a second opinion on it." And he would say, "Send him to the ER." I don't recall the exact conversation, no.

Q. Did he hesitate at all to send him to the ER?

A. He never does hesitate to send them to -- my thoughts on Dr. Larrowe is that he always errs on the side of caution, always. I can't recall a single time that even with something simple that

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could have a negative outcome, that he delayed and said, "All right, just keep them there."

Q. Okay. This is a little different than the other ones. At the end of this --

MR. MYLAR: What number again?

MR. SCHRIEVER: 501.

Q. You've actually got -- where it says R. Borrowman, RN, is there a reason that you put your name in there?

A. Most of the time I do that whenever I put a note in. I don't know if you have any other notes but that was pretty much my standard.

Q. Okay. Are you aware of anything else that happened in Mr. Crowson's charting after he left the jail?

A. (Indicating in the negative.)

Q. Is the answer no?

A. No, I don't recall anything.

Q. Have you ever spoken with him since that you recall?

A. Not that I recall.

Q. Have you ever talked with Dr. Larrowe about this particular patient?

A. No.

Q. Have you ever talked with Michael

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Johnson about this case?

A. No.

Q. How about Josh Billings?

A. Josh Billings, not that I -- I don't think so.

Q. You made a funny-looking face when I asked about Josh Billings.

A. Josh Billings is not one that I would even normally talk to about things like this so I just thought it was interesting that you would even bring his name up.

Q. Was he a nurse at the jail?

A. Yeah.

Q. Did he work there at the same time that you did?

A. Yeah.

Q. Do you know whether he ever saw Mr. Crowson?

A. I don't know. If I did talk to him about it --

Q. You don't recall or you don't know?

A. Yeah.

Q. Okay. Just walk me through quickly the process of sending Mr. Crowson to the ER on July 1st.

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A. So I see that something's the matter. Call Dr. Larrowe. He gives the order to send to the ER. And at that point the deputies take over and they have whatever responsibility they have for making sure the patient's not going to try to escape. I think they handcuff them, put leg cuffs on and stuff like that and then once the doctor's orders are given we let the deputies know or we call 911, depending on the severity. And, to be honest, I don't recall how we sent him here.

Q. Okay. Do you have any reason to either like or dislike Mr. Crowson?

A. No. Neither for or against. I know he was like a lot of inmates who were pretty high maintenance. He would always -- I mean if he had even a little sniffle he would want to be down. But that never made me dislike anybody. I just figured they're human. I know that I've become even a baby when I've had a cold.

Q. Do you know of anyone else at the jail that did not like Mr. Crowson?

A. If there was, I never talked to them. I don't recall anybody.

MR. SCHRIEVER: All right. Those are all the questions I have for you.

MR. MYLAR: Do you have any?
MR. SCHRIEVER: He represents Dr. Larrowe.

EXAMINATION

BY MR. WIGHT:

Q. Just to follow up on 501, 502. There are no entries related to Mr. Crowson for the 26th or the 27th of June. Do you know whether you were working those days?

A. Most likely -- if I was working I was -- I hadn't had booking for a while. That's one thing I remember about this date. So, if I had been working, I was probably in the block doing kites and tasks.

Q. And you don't know who was working those days in the booking area?

A. I don't.

MR. WIGHT: All right. That's all I have. Thank you, sir.

MR. MYLAR: I don't have any.

(Whereupon the taking of this deposition was concluded at 1:55 p.m.)

Reading copy submitted to Mr. Mylar.

Original transcript submitted to Mr. Schriever.

C E R T I F I C A T E

STATE OF UTAH)
)
COUNTY OF)

I HEREBY CERTIFY that I have read the foregoing testimony consisting of 44 pages, numbered from 3 through 46 inclusive, and the same is a true and correct transcription of said testimony except as I have indicated changes on the enclosed errata sheet.

RYAN T. BORROWMAN

Subscribed and sworn to at
this day of , 2018.

Notary Public

My Commission Expires:

* * *

C E R T I F I C A T E

STATE OF UTAH)
)
COUNTY OF SALT LAKE)

THIS IS TO CERTIFY that the deposition of RYAN T. BORROWMAN was taken before me, Linda Van Tassell, Registered Diplomate Reporter and Notary Public in and for the State of Utah.

That the said witness was by me, before examination, duly sworn to testify the truth, the whole truth, and nothing but the truth in said cause.

That the testimony was reported by me and that a full, true, and correct transcription is set forth in the foregoing pages, numbered 3 through 46 inclusive.

I further certify that I am not of kin or otherwise associated with any of the parties to said cause of action, and that I am not interested in the event thereof.

WITNESS MY HAND at Salt Lake City, Utah, this 18th day of April, 2018.

Linda Van Tassell
RDR/RMR/CRR